MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04510

Reg. Dist. No.

Item 1, Film CB 4/28/58 fcy

4520

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mason Springs
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RICHARD Middle: C Last: ASHTON
4. DATE OF DEATH: Month: 4 Day: 20 Year: 1958
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 9, 1931
9. AGE (In years last birthday): 26 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ripley, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Josephine Ashton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mabel Bowman
Address: Pisgah, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage into pleural Cavity — INTERVAL BETWEEN ONSET AND DEATH: 4-20-58
981X
DUE TO (b): 2 bullet wounds of Chest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot by assailant
20c. TIME OF INJURY: Hour: a. m. Month, Day, Year: 4-7½ 1958
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State): Mason Springs Charles Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4-20-58
EXAMINER'S NAME (Type): F. J. EDELEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: April 23, 1958
22c. NAME OF CEMETERY OR CREMATORY: Smith Chapel
22d. LOCATION (City, town, or county) (State): Pisgah, Charles, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Johnson and Jenkins 4804 Georgia Ave. N.W.
24a. REC'D BY REGISTRAR DATE: APR 24 '58
24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4521 CERTIFICATE OF DEATH

Reg. Dist. No. 04511

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaPlata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Hospt

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Point
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ROBERT Middle EUG Last BARBOUR
4. DATE OF DEATH: Month 4 Day 18 Year 1958
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-11-85
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Post Master
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Charles Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Thomas Barbour
14. MOTHER'S MAIDEN NAME: Mary Lucida Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Robert T Barbour Port Tobacco Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2-1-58
DUE TO (b): Hypertension — 1956
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
449 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-21, 19 58, to 4-18, 19 58, that I last saw the deceased alive on 4-17, 19 58, and that death occurred at 2:30 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: E J Edelen M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 4-18-58
PHYSICIAN'S NAME (Type): E. J. EDELEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/21/58
22c. NAME OF CEMETERY OR CREMATORY: Mt Rest
22d. LOCATION (City, town, or county) (State): LaPlata Md

23. FUNERAL DIRECTOR'S SIGNATURE: Richard Inc LaPlata
ADDRESS:
24a. REC'D BY REGISTRAR DATE: APR 23 58
24b. REGISTRAR'S SIGNATURE: W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4522 Items 7,9 Film G228 5-9-58 et

CERTIFICATE OF DEATH

04512

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaPlata
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Marbury Md
f. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Juanita — Middle: — Last: BURGESS

4. DATE OF DEATH: Month: APRIL — Day: 17 — Year: 1958

5. SEX: Fem'l

6. COLOR OR RACE: US-w

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Approx.

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomberry

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Irvin Odell — Address: Marbury Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.
DUE TO (b): CVA — 11 days.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Generalized arteriosclerosis — yrs.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 April, 1958, to 17 April, 1958, that I last saw the deceased alive on 17 April, 1958, and that death occurred at 3:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur Woody M.D. — ADDRESS (Street, city or town, state): LaPlata Md — DATE SIGNED: 18 April 58

PHYSICIAN'S NAME (Type): ARTHUR C. WOODY

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-20-58

22c. NAME OF CEMETERY OR CREMATORY: Park Hill

22d. LOCATION (City, town, or county) (State): Marbury Charles Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Eckhart Inc — ADDRESS: LaPlata Md.

24a. REC'D BY REGISTRAR DATE: APR 24 '58

24b. REGISTRAR'S SIGNATURE: Elsie Couch

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4523 **CERTIFICATE OF DEATH**

04513

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY CHARLES MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CHARLES

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARBURY

c. LENGTH OF STAY IN 1b 45 YEARS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARBURY

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOME : MARBURY, MD.

d. STREET ADDRESS MARBURY, MD.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LLEWELLYN Middle GILLMORE Last DOANE

4. DATE OF DEATH Month APRIL Day 2ND Year 1958

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH DEC. 19TH 1878

9. AGE (In years last birthday) 79 yrs.

IF UNDER 1 YEAR: Months . Days

IF UNDER 24 HRS.: Hours . Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED GROCERMAN

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) HAMPDEN, MAINE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ISSAC DOANE

14. MOTHER'S MAIDEN NAME LAURA COLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-32-9894

17. INFORMANT Address MRS. NELLIE DOANE, MARBURY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY INSUFFICIENCY — INTERVAL BETWEEN ONSET AND DEATH: 24 HOURS

DUE TO (b) CEREBRAL THROMBOSIS — JAN 26, 1958

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) GENERAL ARTERIOSCLEROSIS — YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): HEMIPLEGIA, RIGHT

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL 1ST, 1956, to APRIL 2ND, 1958, that I last saw the deceased alive on APRIL 2nd, 1958, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Paul Chen M.D. ADDRESS (Street, city or town, state) ACCOKEEK, MD. DATE SIGNED APRIL 2ND, 1958

PHYSICIAN'S NAME (Type) PAUL CHEN, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 4/4/58

22c. NAME OF CEMETERY OR CREMATORY Marbury Baptist

22d. LOCATION (City, town, or county) (State) Marbury, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hunt Funeral Home Waldorf, Md

24a. REC'D BY REGISTRAR DATE APR 7 '58

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

Items 18-21 Film 232 8-11-58 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04514

Reg. Dist. No. 4524

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE — Middle VICTORIA — Last FARMER
4. DATE OF DEATH: Month April — Day 7 — Year 19 58
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 18, 1913
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Nicholas Campbell
14. MOTHER'S MAIDEN NAME: Frances Chesley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joseph Farmer, Address: La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Manual Strangulation — INTERVAL BETWEEN ONSET AND DEATH:
983X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Manual strangulation
20c. TIME OF INJURY: Hour o. m. p. m. Found — Month, Day, Year 4/7/58 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Field
20f. (City or town): La Plata — (County): Charles — (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Paul F. Guerin M.D.
EXAMINER'S NAME (Type): Paul F. Guerin, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 4/7/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/10/58
22c. NAME OF CEMETERY OR CREMATORY: Sacred Heart
22d. LOCATION (City, town, or county) (State): La Plata, Md
23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Hunt Funeral Home, Waldorf, Md
24a. REC'D BY REGISTRAR DATE: APR 11 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4525 Item 9 filed 28 5-11-58 et

CERTIFICATE OF DEATH

04515

Reg Dist. No.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pomfret
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pomfret
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: ANGie — Last: Harley

4. DATE OF DEATH: Month: 4 — Day: 23 — Year: 19 58

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Dec 25, 1886

9. AGE (In years last birthday): 71 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: AL Thompson

14. MOTHER'S MAIDEN NAME: Elizabeth Swann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
If yes, give war or dates of service:

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Louise H. Butler, La Plata, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 wks.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Acute Myocardial Infarction — 1 wks.

DUE TO (c): Hypertensive Arteriosclerotic Heart Disease yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 4-11-58 to 4-22-58 that I last saw the deceased alive on 4-22-58, and that death occurred at 5:17 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E. J. Edelen M.D. — ADDRESS (Street, city or town, state): La Plata, Maryland — DATE SIGNED: 4-23-58

PHYSICIAN'S NAME (Type): E. J. Edelen, M.D.

22a. BURIAL CREMATION REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/26/58

22c. NAME OF CEMETERY OR CREMATORY: St Josephs

22d. LOCATION (City, town, or county) (State): Pomfret, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Huntt Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: APR 29 '58

24b. REGISTRAR'S SIGNATURE: C. W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04516

Reg. Dist. No. 4526

1. PLACE OF DEATH a. COUNTY: Charles La Plata Md MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Mass. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Attleboro
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First ERIEDA Middle Last HOLTHER
4. DATE OF DEATH: Month APRIL Day 11 Year 1958
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: May 21, 1884
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HD
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Berlin Germany
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: 9 Benkowski
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Annie Jaegle Providence Ri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) BILATERAL FRACTURES OF FEMURS — 1 min.
DUE TO
(c) AND SCALP LACERATIONS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): HIGHWAY AUTO ACCIDENT - HEAD ON COLLISION
20c. TIME OF INJURY: Hour 7:05 (a. m. / p. m.) Month, Day, Year 4-11 1958
20d. INJURY OCCURRED: While at work ☐ Not while at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HIGHWAY
20f. (City or town) LA PLATA, (County) CHARLES (State) MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: V B Dettor M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 11 April 1958
EXAMINER'S NAME (Type): V. B. DETTOR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-14-58
22c. NAME OF CEMETERY OR CREMATORY: Oak Hill
22d. LOCATION (City, town, or county) Attleboro (State) Mass.
23. FUNERAL DIRECTOR'S SIGNATURE: ADDRESS: Earhart Inc La Plata Md
24a. REC'D BY REGISTRAR: DATE APR 15 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04517

Reg. Dist. No. 4527

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH — a. COUNTY: Charles — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Phy Mem Hospt

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Mass
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Attleboro
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First OSCAR Middle Last HOLTHER

4. DATE OF DEATH: Month APRIL Day 11 Year 1958

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Oct 28, 1883

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleswoman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oslo Norway

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 02-01-9704

17. INFORMANT — Address: Annie Jaegle Providence RI

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 1 hr. 15 min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Multiple Fractures, both legs — 1 hr. 15 min.
DUE TO (c): and Crush Injuries of Chest

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Auto Accident - U.S. 301

20c. TIME OF INJURY — Hour: 7:05 p. m. — Month, Day, Year: 4-11 1958

20d. INJURY OCCURRED — While at work ☐ Not while at work ☑

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HIGHWAY

20f. (City or town) LA PLATA (County) CHARLES (State) MD.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: V B Dettor M.D.
EXAMINER'S NAME (Type): V. B. DETTORRE

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED: 11 April, 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-14-58
22c. NAME OF CEMETERY OR CREMATORY: Elm Grove
22d. LOCATION (City, town or county) North Attleboro (State) Mass

23. FUNERAL DIRECTOR'S SIGNATURE: Orchard Inc
ADDRESS: La Plata Md

24a. REC'D BY REGISTRAR — DATE: APR 15 '58
24b. REGISTRAR'S SIGNATURE:

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4528 CERTIFICATE OF DEATH

Reg. Dist. No. 04518

1. PLACE OF DEATH
a. COUNTY ~~Ad.~~ CHARLES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYS. MEM. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL ALTON
d STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Infant Middle: Last: JENKINS

4. DATE OF DEATH Month: Apr Day: 12 Year: 1958

5. SEX M

6. COLOR OR RACE C

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH 4-11-58

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MARYLAND

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME LOUIS SIDNEY MASON

14 MOTHER'S MAIDEN NAME CECELIA ALICE JENKINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Address: ALICE JENKINS, BEL ALTON MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory collapse — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) prematurity — 1 day

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 4-11, 1958, to 4-12, 1958, that I last saw the deceased alive on 4-12, 1958, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE F M Johnson M.D

ADDRESS (Street, city or town, state) La Plata Md

DATE SIGNED 4-13-58

PHYSICIAN'S NAME (Type) F. M. JOHNSON, MD

22a BURIAL, CREMATION, REMOVAL (Specify) Buried

22b. DATE THEREOF 4/15/58

22c. NAME OF CEMETERY OR CREMATORY Thomas Farm

22d. LOCATION (City, town, or county) (State) La Plata Md

23. FUNERAL DIRECTOR'S SIGNATURE Richard Inc ADDRESS La Plata Md

24a. REC'D BY REGISTRAR DATE APR 18 '58

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

10

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04519

Reg. Dist. No. 4529

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hughesville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First RALPH Middle S. Last JOHNSON
4. DATE OF DEATH: Month 4 Day 15 Year 1958
5. SEX: M
6. COLOR OR RACE: Cn
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: JAN 4 1927
9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Govt
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roy Johnson
14. MOTHER'S MAIDEN NAME: Sara S. Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 219-16-0287
17. INFORMANT: Victorini Johnson — Address: Hughesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4-15-58
DUE TO (b): Brain abscess — 4-15-58
DUE TO (c): Auto accident — 4-15-58
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Auto Accident
20c. TIME OF INJURY: Hour 7 p.m. Month, Day, Year 4-15 1958
20d. INJURY OCCURRED: While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway
(City or town): Waldorf (County): Charles (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: F. J. Edelen M.D.
NAME (Type): F. J. EDELEN
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 4-19-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-22-58
22c. NAME OF CEMETERY OR CREMATORY: St Mary's Com.
22d. LOCATION (City, town, or county): Brantown (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hewitt Funeral Home
ADDRESS: Waldorf Md.
24a. REC'D BY REGISTRAR: DATE APR 23 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4530 CERTIFICATE OF DEATH

Reg. Dist. No. 04520

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physician Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt Victoria
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First WALTER — Middle C. — Last KEYE JR.

4. DATE OF DEATH: Month APR — Day 3 — Year 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: OCT 24, 1925

9. AGE (In years last birthday): 32 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER

10b. KIND OF BUSINESS OR INDUSTRY: COMMERCIAL

11. BIRTHPLACE (State or foreign country): WASH, D C

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WALTER C. KEYE, SR

14. MOTHER'S MAIDEN NAME: DOROTHY FORD

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES — (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 215 26 3636

17 INFORMANT: Dorothy Keye — Address: Mt Victoria Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Diabetic acidosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr 2, 1958 to Apr 3, 1958 that I last saw the deceased alive on Apr 2, 1958, and that death occurred at 3:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: F. Johnson M.D. — ADDRESS (Street, city or town, state): La Plata, Md — DATE SIGNED: 4-5-58

PHYSICIAN'S NAME (Type): F. M. Johnson M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 4-8-58 — 22c. NAME OF CEMETERY OR CREMATORY: Shiloh Met. Cem. — 22d LOCATION (City, town, or county): Newb. Co (State): Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Hunt Funeral Home — ADDRESS: Waldorf, Md.

24a. REC'D BY REGISTRAR — DATE: APR 9 58 — 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04521

FOR STATE HEALTH DEPT.

4531

1. PLACE OF DEATH
a. COUNTY: Charles m.d. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laplata md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Plymmm
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Newport b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):

3. NAME OF DECEASED (Type or print): First JOHN Middle LOUIS Last KNOTT

4. DATE OF DEATH: Month APRIL Day 1 Year 1958

5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 16 1911
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Charles Co
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jemrick Knot
14. MOTHER'S MAIDEN NAME: Mary Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: John W. Knot Address: Newport md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hepatic Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 week

581.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cirrhosis — 1 year

DUE TO (c): Alcoholism — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): no injury

20c. TIME OF Death — Hour: 4:15 e. m. — Month, Day, Year: 4-1-1958
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: V B Dettor M.D.
EXAMINER'S NAME (Type): V. B. DETTOR
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 1 April 1958

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-4-58
22c. NAME OF CEMETERY OR CREMATORY: St marys
22d. LOCATION (City, town, or county) (State): Newport md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Arehart Inc Laplata md.
24a. REC'D BY REGISTRAR DATE: APR 8 '58
24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the cause, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4532 **CERTIFICATE OF DEATH**

04522

Reg. Dist. No.

1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH — a. COUNTY: CHARLES — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata — c. LENGTH OF STAY IN 1b: Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial.	d. STREET ADDRESS: / — e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print)	First: THOMAS	Middle: W.	Last: LYON	4. DATE OF DEATH	Month: APRIL — Day: 30 — Year: 1958
5. SEX: Male	6. COLOR OR RACE: W-	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	8. DATE OF BIRTH: Sept 25, 1869	9. AGE (In years last birthday): 88 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer	10b. KIND OF BUSINESS OR INDUSTRY: Farming	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY: U.S.A.		
13. FATHER'S NAME: James T. Lyon	14. MOTHER'S MAIDEN NAME: Rebecca Lyon				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO: 213-38-2726	17. INFORMANT — Address: Harold Lyon, La Plata, Md.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Respiratory Collapse	20 min
DUE TO (b)	Heart failure.	2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)	Arterio-sclerosis - Cardio-renal disease	10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year: 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21. I certify that I attended the deceased from June, 19 57, to 30 May, 19 58, that I last saw the deceased alive on 30 May, 19 58, and that death occurred at 5:30 A.M., EST, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Wooddy, M.D. — ADDRESS (Street, city or town, state): La Plata. — DATE SIGNED: 30 April 58

PHYSICIAN'S NAME (Type): ARTHUR O. WOODDY — Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 5/2/58	22c. NAME OF CEMETERY OR CREMATORY: Mt Rest	22d. LOCATION (City, town or county): La Plata,	(State): Md.
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The Hunt Funeral Home, Waldorf, Md.	24a. REC'D BY REGISTRAR — DATE: MAY 5 '58	24b. REGISTRAR'S SIGNATURE: [illegible]		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4533

CERTIFICATE OF DEATH

04523

Reg. Dist. No.

Charles County

1. PLACE OF DEATH
a. COUNTY Indian Head MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Had

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Charles
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X
d. STREET ADDRESS /
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print) First ARTHUR Middle M. Last ROSS

4. DATE OF DEATH Month 4-19 Day -58 Year 1958

5 SEX Male

6 COLOR OR RACE Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 6-20-1875

9 AGE (In years last birthday) yrs

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant

10b KIND OF BUSINESS OR INDUSTRY Naval Powder Factory

11 BIRTHPLACE (State or foreign country)

12 CITIZEN OF WHAT COUNTRY? Charles

13. FATHER'S NAME Arthur M. Ross

14. MOTHER'S MAIDEN NAME Mary Ross

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE — INTERVAL BETWEEN ONSET AND DEATH ONE MO.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) ARTERIOSCLEROTIC HEART DISEASE — YEARS

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MARCH 11, 1957, to APRIL 20, 1958, that I last saw the deceased alive on APRIL 20, 1958, and that death occurred at 9:00 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE Paul Chen M.D.

ADDRESS (Street, city or town, state) ACCOKEEK

DATE SIGNED APRIL 20, 1958

PHYSICIAN'S NAME (Type) PAUL CHEN M.D. MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF April 23, 1958

22c. NAME OF CEMETERY OR CREMATORY Mt. Rest

22d. LOCATION (City, town, or county) (State) La Plata, Charles, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Johnson and Jenkins ADDRESS 4804 Georgia Ave. N.W.

24a. REC'D BY REGISTRAR DATE APR 24 '58

24b. REGISTRAR'S SIGNATURE W. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4534 CERTIFICATE OF DEATH

04524
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x La Plata
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANN — Middle: — Last: WALKER

4. DATE OF DEATH: Month: APRIL — Day: 30 — Year: 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-29-58

9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 11 Min.: 33

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: THOMAS JEFFERSON WALKER

14. MOTHER'S MAIDEN NAME: ESTELLA ELIZABETH HUNTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: T.J. WALKER — Address: LA PLATA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PREMATURITY - INADEQUACY OF 774X
DUE TO (b): CENTRAL NERVOUS DEVELOPMENT - EXPECTED DATE OF DELIVERY (7-20-58) — 11 hr. 33 min
DUE TO (c): RESPIRATORY FAILURE — 4 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/29/58, 19—, to 4/30, 1958, that I last saw the deceased alive on 4/30, 1958, and that death occurred at 8:05 A.M. EST, from the causes and on the date stated above.

ACTUAL SIGNATURE: John A. Griffin M.D. ADDRESS (Street, city or town, state): Naylesville, Md. DATE SIGNED: 4/30/58

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 5-1-58
22c. NAME OF CEMETERY OR CREMATORY: St Peters
22d. LOCATION (City, town, or county) (State): Waldorf - Md

23. FUNERAL DIRECTOR'S SIGNATURE: Hunttt Funeral Home, Waldorf, Md ADDRESS:

24a. RECEIVED BY REGISTRAR: MAY 5 '58 DATE:

24b. REGISTRAR'S SIGNATURE:

2166283XY2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4535 CERTIFICATE OF DEATH

Reg. Dist. No. 04525

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x La Plata
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PHILIP Middle Last WALKER

4. DATE OF DEATH: Month APRIL Day 29 Year 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 29, 1958

9. AGE (In years last birthday): ____ yrs. IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours 1 Min. 57

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY: ____

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: THOMAS JEFFERSON WALKER

14. MOTHER'S MAIDEN NAME: ESTELLA ELIZABETH HUNTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): ____

16. SOCIAL SECURITY NO.: ____

17. INFORMANT: T.J. WALKER Address: — LA PLATA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PREMATURITY — INADEQUACY OF 774X
DUE TO (b): CENTRAL NERVOUS DEVELOPMENT — EXPECTED DATE OF DELIVERY (7-20-58) — INTERVAL BETWEEN ONSET AND DEATH: 1 hr. 57 min
DUE TO (c): RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ____

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 ____

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/29, 1958, to 4/29, 1958, that I last saw the deceased alive on 4/29, 1958, and that death occurred at 10:35 AM EST, from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Griffin M.D. ADDRESS (Street, city or town, state): Nanjemoy, Md. DATE SIGNED: 4/30/58

PHYSICIAN'S NAME (Type): ____

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-1-58
22c. NAME OF CEMETERY OR CREMATORY: St Peters
22d. LOCATION (City, town, or county) (State): Waldorf, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Huntt Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR DATE: MAY 5 '58
24b. REGISTRAR'S SIGNATURE: W. Leach

2266284XV2

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.